S. No. 2
-2-43
-17-39
X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

17801

State File No.

FILED JUN 13 1944

Registration District No. 7

Primary Registration District No. 4134

Registrar's No. 62

1. PLACE OF DEATH:

(a) County CLAY

(b) City or town SMITHVILLE, MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: / HOME
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 12 YEARS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County CLAY

(c) City or town SMITHVILLE,
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME ROBERT MAYFIELD

3. (b) If veteran, name war .....

3. (c) Social Security No. 500-07-1183

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ARMINDA CARVER MAYFIELD

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased FEB. (Month) 16, (Day) 1874 (Year)

8. AGE:

Years	Months	Days	If less than one day
70	2	29	..... hr. ..... min.

9. Birthplace HUMANSVILLE, (City, town, or county) MO. (State or foreign country)

10. Usual occupation DAY LABORER

11. Industry or business RAILROAD-----FARM

FATHER
12. Name JACOB MAYFIELD
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name POLLY ANN HARRIS
15. Birthplace UNKNOWN (City, town, or county) 9 (State or foreign country)

16. (a) Informant MAR. EDNA QUEEN
(b) Address SMITHVILLE, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5/17/'44 (Month) (Day) (Year)
(c) Place: burial or cremation PARADISE, CLAY CO. MO.

18. (a) Signature of funeral director McCoy's Funeral Home
(b) Address Smithville Mo.

19. (a) May 25-1944 (Date received local registrar) (b) Ruth N Henry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 15
year 1944 hour 5:40 minute a. M.

21. I hereby certify that I attended the deceased from May 12-44, 19..., to May 12 1944; that I last saw h— alive on May 12-44, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death General Carcinomatosis - 1 — Duration .....

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

Major findings:
Of operations .....

Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) .....

(b) Date of occurrence .....

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature C B Kopp (M. D. or other) M.D.

Address Smithville, Mo Date signed 5-16-44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6-12-44

JUL 3 1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed S. A. McComas

Licensed Embalmer No. 2303

P. O. Address Smithville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 72 Primary Registration District No. 4134 Registrar's No. 62

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Smithville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Robert Mayfield
3. (b) If veteran, name war (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb. (Month) 16 (Day) 187[illegible] (Year)
8. AGE: Years 70 Months 2 Days 29 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5 year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death General Carcinomatosis Duration
Due to Carcinoma of stomach
Due to
Other conditions (Include pregnancy within 3 months of death)
46 L
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

17801